CHILD PROTECTIVE SERVICES IN WASHINGTON STATE

ADMINISTRATIVE ASSESSMENT

Submitted by:

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Acknowledgements

The many persons interviewed: DSHS administrators and staff, law enforcement personnel, representatives of provider agencies, advocates, representatives of the education community, health care, volunteers, foster parents, prosecutors, guardian-ad-litem, representatives of the Governor's Policy and Ombudsman staff; Assistant Attorneys General, and others; were not only generous with their time--but to a person—passionate about the subject of child protection.

The State of Washington owes a debt of gratitude to these persons and the many others like them for their interest and commitment in protecting and nurturing our future generations.

Executive Summary

Washington State child protective services are considered nationally to be among the most effective and innovative in the country. Yet, frequently driven by highly visible 'failed' cases, a great deal of public and political concern has been generated over the last several years about the Department of Social and Health Services, the Children's Administration, and The Division of Children and Family Services.

Our analysis of the issues is not one built on a background of technical knowledge of child welfare or child protective services, nor is it based on a strong background in organizational theory. Rather it is an assessment based on the authors' combined experience of twenty-eight years of administering six different state agencies and the attendant knowledge gained in how state government works, the political/policymaking process, and the strategies for improving organizational health and functioning.

Many earlier studies are available regarding children's services. Many recommendations from those studies have been implemented—some have not. Some of those not implemented should be revisited. (See Section IV).

The provision of services to families and children are surrounded by extremely complex issues. The issues are tradition laden; emotionally charged; politically driven; and resource dependent. No one is opposed to protecting children and strengthening families, but there is a great deal of debate on how and when it should be done and who should do it.

This report begins with the premise that the Children's Administration, the Division of Children and Family Services, and Child Protective Services are 'doing good work'. It then makes a series of recommendations that could result in a 'healthier' organization. Healthier organizations allow employees greater job satisfaction, enhance qualitative and quantitative productivity, and encourage innovation. This results in better outcomes for clients and the public in general.

Recommendations are made that build on existing strengths, that address some of the reported and observed problem areas, and also suggest some longer term issues and strategies that should be considered in order engage all citizens and communities in these issues in the future.

The report suggests that major efforts should be made to move the organizational culture from one of fear and feeling 'victimized' to a "culture of trust"; that the ambivalence that sometimes exists between the protection and

safety of the child and the preservation of the family should be clarified; and that staff turnover and vacancies should be addressed.

The report also recommends streamlining ‘administrative tasks’; enhancing the process for increasing number of foster and adoptive homes; and improving external communications.

In the longer term it is suggested that a vision should emerge that would allow DSHS and the Children’s Administration to ‘do business’ in a different way’ to meet future challenges and needs.

Foremost is to think about engaging communities in the challenge of protecting and nurturing children and of strengthening families where appropriate. It is recognized that this is a major undertaking.

Other longer-term consideration is recommended regarding developing a vision and strategy that addresses the insidious impact of substance abuse, domestic violence, and neglect.

I. Overview

The 1991 National Commission on Children charged: " If the nation had deliberately designed a system that would frustrate the professionals who staff it, anger the public who finance it, and abandon the children who depend on it, it could not have done a better job than the present child welfare system."

One individual interviewed in this assessment stated: "The State of Washington does not make a good parent for children".

Although considered a top tier state in many areas of child protection, Washington State, like most jurisdictions in the country, continues to struggle with the issues of child neglect and/or abuse. While the basic premise and philosophical principles of protecting children are generally agreed upon, consensus has never been reached on who should do it, how it should be done, and when it should be done.

Clearly, balancing the tension between the 'sanctity of the family', parental rights, privacy rights, and the 'well-being' and safety of children is the primary challenge from a policy, as well as an operational perspective. The old cliché of "…you are dammed if you do and you are damned if you don't…", is a daily reality for those working in the field.

Years ago, for-profit and non-profit child welfare and advocacy agencies played the primary role in the provision of services to children. Today, the primary responsibility and authority for responding to allegations of abuse or neglect is vested in state or local government agencies, with specific services provided by non-profit and for-profit agencies under contract to governmental agencies.

Much of the policy regarding the protection of children has been driven by federal action and funding (e.g., the Social Security Act of 1935; the Child Abuse and Treatment Act of 1974;and the 1997 Adoption and Safe Families Act).

Funding from the Federal government has frequently not been sufficient to cover the accompanying mandates to state and local government. Indeed, categorical and specified funding streams have often been detrimental or prohibitive to providing adequate resources to Child Protective Services (CPS) or services supportive to children and families.

Many speculate that recent initiatives such as welfare reform have increased the likelihood of family break down, and in turn the safety and quality of life of many children. At best, resources are generally directed to reacting to

instances of abuse and severe neglect, with limited funding available from any governmental source for prevention.

Since the mid- 1970's several factors seem to have made this whole issue of the protection of children more complex. A proliferation of more prescriptive federal and state laws have reduced discretion and increased red tape for courts and child welfare agencies. More families present multiple causative factors contributing to child abuse and neglect (substance abuse, divorce, domestic violence, mental illness, economic stress and low educational achievement.)

Policies, procedures, and standards have been developed by the Washington State Department of Social and Health Services (DSHS) with the anticipation that they will be applied consistently across the state. This has its advantages and disadvantages. The advantages include increasing predictability for those working with and for the organization, avoiding litigation, standardizing operational response, and assignment of risk. Disadvantages include losing case uniqueness; disregard of community and cultural strengths, values, and weaknesses; creation of burdensome record keeping and heavy reliance on standardized instruments. Ironically, in instances of litigation, courts most often judge the agencies actions as to whether they are in compliance with their own policies. The more of them and the more specific they are---the greater the likelihood the agency will be found liable

The tension between the goals of family preservation and the safety and protection of the child is greatest when either goal is carried to extreme. Hasty removal of a child from the family may be traumatic to the child and inhibit the family's ability to improve. Conversely, failure to remove the child from an abusive or neglectful situation may result in permanent harm or even death.

It is difficult for policymakers and child workers alike to strike a fully acceptable balance between these goals. Policymakers may authorize, prohibit, or require certain behaviors. So many of the actual decisions rely on the judgement of individual workers, with varying degrees of statutory or agency policy guidance.

The challenge of defining 'neglect' has confounded policymakers. Cultural, socioeconomic, religious, and jurisdictional differences all make universal definition difficult. This lack of definition ties the hands of professionals charged with reporting, investigating, and making judgements regarding alleged neglectful situations. Most persons working in the field of child protection are of the opinion that the area of chronic neglect is one of the greatest challenges facing the child welfare system today.

The media's extensive coverage of tragic outcomes in child abuse and neglect cases colors public perception of the agency and its workers who are

tasked with the protection of children. Several such cases in the last few years have focused attention on the DSHS and its child protection workers. The faces remembered by the public are the pictures of the child that died or was severely injured. One law enforcement official stated: “There is no way to defend against a dead child”.

Yet, literally thousands of children per year are saved from serious harm or have their lives vastly improved by the same agency and workers so frequently criticized.

As is true with many services that are publicly provided, the issue of adequate resources is a constant challenge. Caseload size, available treatment, numbers of foster homes, specialized residential facilities, information systems, equipment, money to fund treatment modalities, and management capacity are but some examples of resource needs that seldom will be agreed upon in terms of quantity or quality. Most persons directly involved relate that caseloads are too high, too few treatment programs are available, and not enough safe placement options exist.

CPS staff must interact with law enforcement, educators, social workers, friends and neighbors, courts, prosecutors, health care providers, and relatives to properly assess the presence of unsafe or neglectful situations. A strong network must be established to respond quickly and effectively to potential or real neglect and/or abuse. The term ‘seamless’, although a desirable goal, does not apply to the protection of children in Washington.

Assessing the risk of neglect or abuse to a child once a referral has been received is a critical decision point in the protection process. Unfortunately, but understandably, the risk assessment process and tools become more a means of managing work than actually assessing the risk to the child.

High staff turnover due to stress and burnout is the norm in this state and others. This results in more workload to be shared by remaining workers, increased stress, inability to meet work standards, and therefore more likelihood of a failure. Certainly the high visibility of ‘failures’, the intensity of constantly seeing children in deplorable conditions, and the weight of making critical judgement calls contribute significantly to this turnover. Few human service workers are called upon to face such foreboding responsibilities on a daily basis.

The complex issues of protecting children have been debated by the state legislature for many years. Some have suggested the solution to be a structural one (e.g., creation of a separate Department of Children’s Services). Others call for more resources for any variety of services for families and children. From time-to-time resources have been added. But, as one official said: “We keep doing the same thing—and expect different results.”

II. Methodology

This assessment of the Department of Social and Health Services (DSHS) protection of children was approached through the review of several relevant studies of children's services in other jurisdictions; review of literature describing initiatives and trends in child protective services in other jurisdictions; a review of DSHS studies, statutes, policies and procedures; and through interviews of a number of persons within and outside of the Department who are involved or interested in the protection of children.

Persons interviewed included: former DSHS Secretary Quasim; former Deputy Secretary Reed; two other former DSHS Secretaries; the Assistant Secretary for Children's Administration; the Director of the Division of Licensed Resources; the Director of the Governor's Children's and Families Ombudsman Office; the Governors Policy Office representative; three Regional Administrators; four Area Managers; two sets of foster parents (and foster child); the Children's Administration Chief Researcher; a CPS Intake Worker; and several CPS teams from Olympia, Seattle, and Everett Regions.

Also interviewed were staff from the Children's Administration Program and Policy Office; four Assistant Attorneys General; a volunteer and Regional Advisory Board member; the Seattle CPS African American Unit; numerous (over 16) individual CPS and Division of Licensed Resources social workers; numerous front line CPS supervisors (individually and in groups); members of a Child Protection Team; a school nurse; a Judge; a Public Health supervising nurse; a Deputy Regional Administrator; CPS Native American Unit Staff; a guardian-ad-litem; law enforcement representatives (two Sheriffs, two Police Chiefs, and two investigators) and prosecutors.

Also interviewed were representatives of Casey Family Services; Childhaven; the Children's Protection Team at Children's Hospital and Regional Medical Center; the Department of Social Work at Harborview Hospital; the Children's Alliance; the Washington Association of Sheriffs and Police Chiefs, the Washington Children's Home Society, the Washington State Association of School Principals, and the Families for Kids Initiative.

Due to time constraints we were unable to personally interview staff from Eastern and Southwest Washington, and many other interested and involved professionals and citizens. We are not subject experts in child welfare nor child protective services. The assessment is focused on the management of a large state agency.

III. Observations and Recommendations: What is working well.

Improving Performance through Innovation and Learning:

The Assistant Secretary of the Children's Administration has created a climate that encourages innovation. Many new approaches are being piloted in offices around the state. Examples include permanency planning in Spokane, staff retention in Kent, accreditation in Vancouver, new partnerships in Omak, neglect wrap around services in Vancouver, developmental testing in Seattle, and substance abuse wrap around services in Port Angeles. Successful programs have been tested in other states as well.

Recommendation 1: Develop timely methods for operationalizing successful innovations statewide.

Recommendation 2: Actively learn from, and benchmark successful models from other states. Participate in multi-state forums that will inform management and staff about successful new approaches elsewhere.

Support Services:

Excellent support services are cited repeatedly by CPS workers as essential to successful outcomes: e.g. Family Preservation Services, Intensive Family Preservation Services, Homebuilders, Therapeutic Child Development, chemical dependency counselors outstationed in CPS offices, etc. However, no functional, current list exists for staff of community programs that includes available openings.

Recommendation 3: Develop and provide CPS workers with a current list of community support services with available openings.

Family Involvement:

Some regions make extensive use of Family Group Conferences and other techniques that involve the extended family in problem resolution and lead to more relative placement and increased positive outcomes.

Recommendation 4: Encourage all regions to emphasize this practice. Track for evaluative purposes.

Community Involvement:

Collaboration, community partnering, coordination with the community, Family Service Networks, and Community Protection Teams were all given as examples that contribute to better outcomes.

Recommendation 5: Leadership must establish clear expectations for all offices to coordinate closely with community partners with the goal of creating a seamless network of support.

Dedicated Staff:

Staff at all levels are dedicated to the protection of children. Numerous wonderful success stories were shared of removing children from dangerous situations, placing children in caring/nurturing foster/adoptive homes, and working to strengthen families.

Recommendation 6: Build on successes; develop a 'culture of trust' in the agency; recognize and reward publicly the good work—both situational and sustained.

Strides in Automation:

The implementation of the Case and Management Information System (CAMIS) has improved the ability to capture client information and begin to analyze trends and worker action. The information will only be as good and useful as the quality, and timeliness of the input. Upgrades and improvements are underway. Strategies for making the system more user friendly and less time consuming are being considered.

> *Recommendation 7: Means of quality assurance of data entry should be developed. Streamline data entry. Eliminate redundant capturing or retention of information - the tendency is to continue past requirements (such as hardcopy files) when electronic files could suffice*.

Medical Consultation Network:

The Medical Consultation network is a valuable, comparably inexpensive service, that seems to enhance the confidence of workers in making tough decisions and force thoughtful thinking about alternatives.

> *Recommendation 8: Continue and enhance the network as needed. Workers should be trained or informed regularly about its use.*

Attempts to Manage Cultural Differences:

Pilot projects such as the CPS African American Unit and the Native American Unit in Seattle are noteworthy in that sincere attempts are being made to address cultural bias in service delivery and decision making. The fact that the pilot is also being evaluated is also to be commended.

Recommendation 9: Continue similar projects with other groups statewide that may benefit from cultural/language sensitivity.

Funding For Services:

Recently it seems that the Children's Administration has been working toward integrating funding to better meet the specific needs of children and families with multiple problems. The concept of 'blended funding' is becoming more of a reality under both Federal and State law.

Recommendation 10: Continued pursuit of 'blended funding' opportunities, seeking greater authority where necessary from Federal and State authorities. The concept of having the 'money follow the child should also be pursued.

IV. OBSERVATIONS AND RECOMMENDATIONS: WHAT CAN BE STRENGTHENED.

Clarity of Mission:

An insidious problem for CPS staff is the lack of clarity of mission. Although many of the persons interviewed stated they felt the mission was clear, there was a disturbing disparity when staff describe the mission and how it influences their day to day decisions. The greatest area of ambivalence is whether priority should be given to the safety and well being of the child, or to preservation of the family. State law, federal law, agency policy, and personal or professional beliefs allow a great deal of discretion in interpreting and operationalizing a response to reports of neglect or abuse. This ambivalence can compromise decisions that are in the best interests of the child.

State and national statistics indicate that an overwhelming number of the children in foster placement for ninety days will end up in long term foster care with ultimate termination of parental rights. Thus it is important to move quickly to create alternative, permanent stable relationships for the child. Unfortunately the competing priorities of child safety and family reconciliation create dilemmas that prevent expeditious case resolution. Sadly, most cases that have gained widespread public attention in recent years have been those in which decisions have been made erring on the side of family reconciliation.

Recommendation 11: The agency policy and/or state law should clarify as succinctly as possible priorities for CPS staff in instances of alleged or real abuse and neglect. At present, child safety and family reconciliation are viewed as competing priorities, often delaying successful resolution of cases.

Regional Accountability and Authority:

Regional Administrators have authority to structure service delivery in their own regions. This autonomy creates issues in consistency of practice standards (different screening criteria), lack of uniformity (adoption of new policies and procedures), access (reportedly 50% of incoming phone calls in

some areas are wrong numbers), information sharing, and communication. Critics contend that this contributes to community provider confusion and discomfort on continuity of care for children and families. Inconsistencies in practice can also cause community provider/reporter hesitation in referring cases and/or seeking assistance.

Advocates for autonomy of regional structural decisions argue that it allows offices/regions to more closely reflect community values/differences.

> *Recommendation 12: Establish baseline expectations for consistency, e.g., practice standards, protocols, checkpoints, etc. Make it the job of leadership (Regional Administrators through supervisors) to assure their consistent attainment. Community values/mores should enhance, not modify, these baseline standards.*

Workload Management:

Maintaining a reasonable workload, which matches up staff skills and experience with client risk, is critical to successful outcomes for children and families. Past management studies of CPS have addressed the barriers to workload management. Many changes have resulted in improvements in this arena – reduced caseloads, automation, addition of clerical staff, training for staff and supervisors, improved management skills, and increased compensation.

However, the fact remains that line staff turnover continues to be as high as 50% per year in some units – with stress, fear of failure and low job satisfaction cited as underlying reasons. Barriers to reasonable workloads include relentless change and new demands for accountability. This increases staff time spent in training and case documentation, and decreases time available for children, families and community networks. Efforts to simplify and streamline operations are outpaced by new policies and procedures, which add complexity.

Staff vacancies present another barrier to workload management. This is caused by hiring delays originating in Olympia (DSHS and the Department of Personnel) and additional requirements placed on hiring decisions by some Regional Administrators. The result is that some positions are vacant for up to six months. This increases the actual workload for those remaining, increases

the number of workers managing a single case and increases the time it takes to resolve a case.

Turnover and vacancies also contribute to bad outcomes. Most supervisors state it takes three years for the average CPS worker to become proficient. One office funded for 12 positions actually had three filled positions. Turnover creates a "revolving door" with less experienced workers entering and seasoned workers leaving for work that provides them less stress and/or more job satisfaction.

Regional administrators and area managers often spend as much as two days a week in management team meetings - much of that time discussing new rules and changes. This leaves little time for them to nurture community networks or to work with offices, staff and stakeholders. Staff and supervisors complain that managers are out of touch with the new realities of case management. Some describe a "trust gap" that exists between management and staff.

Recommendation 13: Create other methods for communicating change with managers, such as email and teleconferencing, so that more time can be spent accompanying workers in the field.

Recommendation 14: Rather than allow workers to be overloaded when an office has many vacancies, the agency should establish a process to formally waive work on specific tasks so that standards can continue to be met on priority tasks.

Recommendation 15: Streamline the hiring process. If reasonable workload increases successful outcomes, then eliminate the barriers to recruiting and retaining a full complement of staff. Put the burden on regional administrators and area managers to keep the hiring process moving quickly. DSHS should work with the Department of Personnel to establish continuous recruitment lists from which eligible candidates can be 'pre-qualified' and hired quickly.

Recommendation 16: Decrease the time it takes to achieve staff confidence and competence by experimenting with teaming with a more seasoned worker. Increase the time available by supervisors for mentoring and coaching.

Recommendation 17: Increase retention rates by providing greater opportunities for flexible schedules, job sharing, telecommuting, and sabbaticals. Create job rotations to allow "timeouts".

Recommendation 18: Increase tools available, which contribute to worker effectiveness; e.g. access to state cars, laptop computers, recorders, cell phones. The payback in terms of worker time and satisfaction will quickly justify the initial costs.

Recommendation 19: Don't stint on worker recognition – internally and externally. A well-received, popular recognition program is a great reinforcer of mission and values.

Recommendation 20: Examine creation of new and higher job classes for experienced workers that allow higher salary without moving into supervisory ranks. One approach would be a "certification" process that, through experience and testing, would allow field workers to progress to greater levels of independent practice.

Align Supervisor's Authority, Responsibility and Accountability:

Past studies have dwelt on the pivotal role played by supervisors. They are simultaneously defined as clinicians, counselors, trainers, and mentors. They are also the glue that binds staff and management by effectively translating management expectations into staff performance. Yet, many of them do not consider themselves as part of management. This subtle issue has many ramifications – indeed it impacts the type of people hired in supervisory positions and the skills they are required to posses. We would argue that supervisors are

managers. This implies they will be given the responsibilities, authority and accountability needed to carry out critical functions such as hiring and supporting new workers, assuring staff compliance with standards and time frames, accompanying the workers into the field on a regular basis, effectively managing workload – in short doing what needs to be done to assure a high level of performance from their staff. Currently many of these functions are carried out at different levels of management in different regions, contributing to fuzziness of expectations and unclear lines of accountability.

Recommendation 21: Clarify the management responsibilities and roles for supervisory staff. Create greater alignment between authority, accountability and responsibility for supervisors. Supervisors are the critical link in the chain of accountability that begins with the CPS worker and goes through the DSHS Secretary to the citizens. Increase the time available for supervisors to guide and grow staff. Decrease the time through automation or delegation needed for routine monitoring tasks.

Redundant Efforts, Paperwork, Non-Critical Duties:

"Too much time spent pushing paper – too little time for working with families." Many CPS workers spend the bulk of their time documenting cases, preparing for court, filing court papers, responding to public disclosure requests, and records maintenance. While clerical staff have been added, many administrative/clerical functions still reside with the CPS worker.

Transporting children to dental and other appointments is another example of non-critical duties often performed by CPS workers.

Redundant documentation requirements still exist. For instance, when a law enforcement investigator and CPS worker are in the same interview, procedures require both to document that interview. The officer audio records the interview and CPS worker takes handwritten "verbatim" notes. The officer then turns the tape over to a clerical person for transcription, and the CPS worker has to enter his/her notes into CAMIS often with the requirement to produce an additional hard copy for court documents.

Recommendation 22: Provide additional administrative/clerical support staff to reduce the paperwork and document management requirements for CPS workers. Make greater use of other para-professionals or volunteers to assist in non-critical duties.

Recommendation 23: Eliminate duplication of effort in case documentation, e.g. writing down then entering in CAMIS, often two people recording the same information. The pilot projects examining use of audio and/or video recorders should be accelerated

Foster Care/Adoption System Capacity:

Many documents and people interviewed point to the lack of available foster care placements as a major barrier to quick identification of alternate, permanent, stable relationships for children without a viable family option. This lack is attributed to a number of factors: inadequate reimbursement; few recruitment or public education campaigns; a slow licensing process; inability to come to quick resolution of allegations about foster families (even when foster parents self-report); and a failure to treat foster families as partners.

While attempts are made to help foster children interact with peers as normally as possible, many foster requirements prevent this. For instance, foster children may not stay the night at a friend's house until a social worker has completed a background check on the friend's family. A foster child may not participate in some activities and sports programs without the permission of the social worker.

Many foster children find themselves in a kind of limbo because of the backlog of processing paperwork necessary to complete adoption. Many of these legally free children are in their pre-adoptive homes 0ne individual called them 'legal orphans'. Efforts are underway to eliminate the backlog through decentralizing the process.

Information about becoming a foster or adoptive parent is not readily available. One foster mother reported it took six long distance telephone calls before she connected with the correct office to inform her about adoption.

Recommendation 24: Create incentives for more people to become foster parents, for instance, one city is using HUD funding to provide housing incentives for foster parents.

Recommendation 25: Rules appear too restrictive for foster parents. Engage foster parents and foster children in a redesign of those rules to reduce the barriers they create for potential foster families and children.

Recommendation 26: Allow foster parents access to court hearings.

Recommendation 27: Intensify the publicity about the need for foster/adoptive parents. Consider contracting with a non-profit or for-profit agency to recruit foster/adoptive parents.

Recommendation 28: Revisit the foster care compensation system. Eliminate the financial penalty for foster parents who have two or more siblings. Create incentives for relative/family placements.

Recommendation 29: Develop a problem solving fast track for foster care incidents in which the foster parent has self reported.

A Focussed, Strategic Style for Headquarters

It is critical for organizations under fire to have strong, mission driven leadership. DSHS headquarters staff describe “constant interruptions” as the norm - with little or no time to focus on strategy and mission. This crises-driven

environment contributes to a defensive leadership style. Knee jerk policies, more change, new forms, more documentation, increased accountability and complexity are often the unfortunate result.

Since the Creekmore case a culture of "retaliation" has emerged which leads to a punitive response when a child fatality occurs. This exacerbates worker frustration and turnover, increases caseloads, and delays successful case resolution.

> *Recommendation 30: Leadership must focus on mission and strategy. It must clearly articulate the beliefs critical to Children's Administration. It must foster greater trust among citizens that it is working in everyones best interest. This trust can be enhanced by managing the public's expectations about what the agency can and cannot guarantee. When bad things happen, as they surely will, the agency must get back to the mission driven message, and not get totally sidetracked by the crisis. It is important to all that a 'climate of trust' be developed—trust between the staff and the administrators; between staff and clients; between the agency and partners; and between the agency and the community.*

A Sustained Program to Educate, Inform and Engage Citizens:

There is no consistent, conscious effort to educate the public, the media, or the communities about the work of the Children's Administration. . As a result there is a lack of knowledge about the hundreds of success stories involving at risk children, a lack of information about the benefits of being a foster or adoptive parent, a lack of awareness of the causes of child abuse and neglect and its consequences to society, and a lack of understanding about the responsibility of all to create healthy communities where children can thrive.

> *Recommendation 31: The Secretary of DSHS and the Children's Administration Assistant Secretary, Regional Administrators, and Area Managers should begin an aggressive communication strategy to educate, inform, and engage the citizens in preventing*

child abuse and neglect. Meet with community leaders, editorial boards, community groups to tell the story that child abuse/neglect is everyone's business. Understand your responsibility to get the word out in a consistent, active, and strategic way. It is important to 'put a face' on the success stories and the workers behind them. Craft and carry out a viable communication strategy.

IV. RECURRING RECOMMENDATIONS

Part of the document review included the following studies of CPS conducted during the past several years:

- Crisis in Children's Services: The Report of the Governor's Child Protective Services Review Team (March 1987)

- An Examination of Organizational Structure and Program Reform in Public Child Protective Services, Washington State Institute for Public Policy (December 1996)

- Final Report and Recommendations of CPS Symposium Workgroup (December 1996)

- The Reports of the Deloitte and Touche Consulting Group (Jan-March 1997)

It is encouraging to compare the recommendations of these reviews and studies to the progress made by the Children's Administration in the last decade. Progress such as:

- Implementation of CAMIS;

- Creating a distinct Children's Administration;

- Formalization of training modules for CPS workers, supervisors, courts, law enforcement, schools, health care, etc.

- Implementation of Community Protection Teams;

- Development of a Risk Assessment Tool:

- Implementation of the Indian Child Welfare Act;

- Addition of clerical support staff:

- Increased collaboration and liaison with community partners.

We applaud these improvements. Many people commented favorably on their results.

However, it is puzzling to encounter recommendations that have appeared repeatedly without any response. We can only speculate that some combination of timing, political will, resource scarcity, or professional judgment has precluded their adoption.

Based on our assessment, we feel compelled to echo some of these recommendations. We urge a renewed consideration of operational and leadership issues such as:

- Systematic and timely adaptation of successful innovations;
- Eliminate competing priorities for child safety and family reconciliation .
- Clarify management role and responsibilities for supervisors;
- Embark on an aggressive communication strategy to engage and inform citizens about their role in preventing child abuse and neglect;
- Practice a leadership style that is mission driven and strategic.

V. CONCLUSION

Too frequently assessments such as this one focus on the problems in an organization. As is true of any organization, improvements can be made in the DSHS Children's Administration

However, it is important to continue to stress that the staff of these organizations are daily serving the children and families in the state of Washington quietly, skillfully, and with considerable commitment. Literally thousands of children and families each year are protected and strengthened through their efforts.

A number of recommendations have been made to improve practices, procedures, or policies in the Children's Administration that may improve services to children and families in the short term.

However, no short-term strategies will address two persistent causes of child abuse/neglect – those of substance abuse and domestic violence. Neither are there any strategies to deal successfully with victims of neglect.

There has been tremendous progress from the old agency posture of isolated expert toward one that is open and collaborative. However, we heard repeatedly that leadership is defensive and lacks a strategy to engage communities in the goal of preventing child abuse and neglect. Thus, by the time CPS workers are called in, the problems of child neglect and abuse have complex and their solutions costly.

That is why we argue for a significant shift toward a paradigm that engages and involves communities in a comprehensive way. It begins with a strong message that this administration cares about keeping kids safe; that it intends to do whatever it takes to earn the confidence of citizens; and that mistakes will happen when organizations deal with the issues of child abuse and neglect. This becomes the starting point for building understanding and public trust.

Next leadership exhorts communities, "if you are concerned about children, we want to talk with you; we want to know what we can do to help families in your communities; you see problems long before we hear with them – join with us and help us."

The Role of the Community

Arguably, the 'community' in our society has the primary responsibility —after the family—for the safety and well being of our children. If we accept that premise, then the question becomes: How do we more fully engage our communities and its citizens in this responsibility?

There are other public issues and services that may provide some thought provoking examples. Law enforcement is primarily provided at the municipal and county level. Water and fire districts are comprised of locally elected officials, as are growth management and planning boards. Kindergarten through high school education is provided primarily through local school districts with state financial and technical support with accompanying state standards and monitoring. Such models have been created to allow local 'control' consistent with baseline state-wide standards designed to assure minimum provision of services to all of the state's citizens, but that local differences or preferences are accommodated within those parameters.

This does not argue that the state role in providing the services should be diminished. Rather, the role that communities play in protecting children and strengthening families should be expanded and enhanced.

Attempts have been made over the years to encourage such partnerships, and indeed strong relationships have been developed in some communities across the state. These generally seem to occur when there is strong community leadership accompanied by receptivity on the part of local agency staff. Missing is an overall strategy that would encourage community involvement and leadership as a primary focus of the State's approach to protecting children and strengthening families.

(One 'out of the box' example would be to encourage the creation of "…children and family councils…" in each school district in the state. School districts are already geographically defined, have some sense of community, and already are in the business of children. Offering small grants of money to establish and support such councils and providing technical assistance and training would be incentives to them. The councils could have as their responsibilities the identification of resources available to protect children and strengthen families, identification of gaps in services, development of new services, etc.) This, of course, is not necessarily the approach to be pursued, but simply illustrative of 'different ways' to do business.

Numerous models could be explored to enhance the community involvement in the protection of children. Several law enforcement officials

suggested co-locating CPS workers with the law enforcement personnel charged with investigating child and family complaints. They believe that inter-agency communication (personal and electronic) would be greatly enhanced by such models. Such relationships could also be explored in other areas (such as schools).

Enhanced feedback loops to mandatory reporters as to whether action has been taken (and within confidentiality limitations what that action is taken) would greatly strengthen relationships with other community members. This communication concern was mentioned by numerous individuals, particularly school nurses, teachers, principals, and community providers.

A question that must be asked in thinking about enhancing community involvement is: Is government the entity to undertake the tasks necessary to pursue such an initiative? Public education, marketing, recruitment, and community organization are but a few of the tasks required. Government agencies have seldom displayed the ability—nor arguably have the capacity and resources—to do these tasks well. Many non-profit agencies and certainly some private organizations have better track records in this arena.

The entire area of 'community partnerships' (contractual and non-contractual) is one that should be explored in depth.

Domestic violence, substance abuse, neglect, and prevention

Substance abuse on the part of a parent or caregiver is estimated to be a contributing factor in abuse or neglect in over seventy percent of the cases. The stated need is for readily available, quality treatment programs. CPS workers also identified a need for increased skills in recognizing substance abuse (Several anecdotal stories were shared relating to incidents in which a child was removed from the parental home until the caregiver(s) completed substance abuse treatment, and the caregiver(s) were on a waiting list for months before they could even begin treatment—the child having to remain in foster care due to that backlog). Long-term, greater definition should be given to this problem.

Many persons believe that in any instance of reported domestic violence in which there are children in the home, an assessment should be made as to the potential harm children. The nexus between domestic violence and short and long-term damage to children needs to be better understood. Also the policy conflicts between domestic violence and child abuse must be speedily resolved.

Almost to a person, those persons interviewed stated that one of the most misunderstood areas is that of chronic neglect. Most individuals relate that the definition of neglect is unclear. It is clear that children raised in environments in

which they are neglected are poorer students. They appear more frequently in juvenile courts, are more susceptible to teen pregnancy, etc. Long-term initiatives should address these issues.

Prevention in any human service field is universally seen as desirable, but seldom sufficiently funded. This generally occurs because determining with specificity causative factors is difficult, research is difficult, and the tendency to want to spend money to 'fix' known problems rather than to prevent the problem. Funding of small but definitive research projects testing preventive approaches could be a very sound monetary (and human) investment for the future.

The political will to maximize the protection of children too often has coalesced in response to one or two high profile cases. This then often takes shape as the need to 'reform' something. In pursuing a 'better future' and in considering a "paradigm shift" a thoughtful strategy should be pursued that engages the agency and the community in creating that future. The subjects of protecting children and building healthy families find few opponents until the details and priorities are spelled out. A "children's campaign" launched by strong, committed leadership could result in that different future.

Appendix A. : Washington Documents Reviewed:

" The Children's Administration 1997 Performance Report"; DSHS; July 1998.

DSHS Budget Facts (1999-2000 biennium)

Overview: Children's Administration

Overview: Office of Family and Children's Ombudsman

Office of the Family and Children's 1999 Annual Report

Final Reports: "Decision-making in Child Protective Services: A Study of Effectiveness (Phases I and II)

Sample Investigation Reports

Sample Individual Service and Safety Plans

Reports Audits and Evaluations

Budget Summaries

Risk Assessment and Evaluation Tool Samples and Tools

Supreme Court *Tyner Decision*

Lauria Grace Fatality Review

Annual Report on 1998 Child Fatalities

Performance Agreement for Children's Administration

Washington State CAPTA Plan 1999

Basic Law Enforcement Agreement

Draft of Curriculum Outline for CPT Handbook

Fact Finding Report of Child Fatality-Morgan Mohler

Community Child Fatality Review Team Summary-Morgan Mohler

Applicable State and Federal Statutes

Applicable Washington Administrative Codes

Administrative Policies

Administrative Procedures and Protocols

Flow Charts

CPS Job Descriptions

CPS Hiring Policies

DSHS, Children's Administration, and other relevant Organization Charts

Examples of Performance Expectations and Performance Evaluations

Reports and data regarding staff turnover, levels, and disciplinary actions

Training Plans

Training Curriculum

Reports regarding training frequency

"Crisis In Children's Services"—The Report of the Governor's Child Protective Services Review Team—March 1987

Appendix B. : Literature Reviewed:

"Child Protective Service Task Force Report to the Commissioner of the Department of Human Resources: State of Georgia"*;* April 20,2000.

"Tools of the Trade: Supporting Good Decisions"*;* Diana English, Ph.D.; New Brunswick, New Jersey; May 18, 2000.

"Risk Assessment in Child Protective Services: Consensus and Actuarial Model Reliability"; Baird, C.; Wagner, D.; Healy, T.; Johnson, K.; Child Welfare Journal; November/December 1999.

"A New Approach to Child Protective Services: Structured Decision Making"; Children's Research Center; 1999.

"The Michigan Department of Social Services Structured Decision-Making System: An Evaluation of Its Impact on Child Protection Services"; Children's Research Center; March 1995.

"Guidelines For Alternative Response to Reports of Child Maltreatment"; Minnesota Department of Human Services, Family and Children's Services Division; April 2000.

"State of Wisconsin Generic CPS Structured Decision-Making: Policy and Procedures Manual"; Children's Research Center; May 2000.

" The Relative Validity of Actuarial and Consensus-based Risk Assessment Systems"; Baird, C. and Wagner, D.; Youth Policy Journal; June 2000.

" Child Abuse and Neglect Fact Sheet"; National Information Clearinghouse; April 2000.

"Child Abuse and Neglect: Improving Consistency in Decision-Making"; Focus; National Council on Crime and Delinquency; August 1997.

"Protecting Children From Abuse and Neglect: Analysis and Recommendations"; The Future of Children; Vol.*-No.1; Spring 1998.

"Past, Present, and Future Roles of Child Protective Services"; The Future of Children; Patricia Schene; Vol.8-No.1; Spring 1998.

“Rethinking the Paradigm For Child Protection”; The Future of Children; Jane Waldfogel; Vol. 8-No.1; Spring 1998.

“ The Decision to Investigate: Understanding State Child Welfare Screening Policies and Practices”; Urban Institute Series; Tumlin, K. and Geen, Rob; May 2000.

“Supervising Child Protective Caseworkers” Morton, T. and Salus, M.; U.S Department of Health and Human Services; 1994.

“The Role of Law Enforcement in the Response to Child Abuse and Neglect”; Pence, D. and Wilson, C.; U.S Department of Health and Human Services; 1992.